REPORT ON THE STATUS OF WOMEN IN BLOOMINGTON AND MONROE COUNTY
CITY OF BLOOMINGTON COMMISSION ON THE STATUS OF WOMEN

HEALTH AND WELL BEING

October, 2007

Report on the Status of Women in Bloomington and Monroe County
Commission on the Status of Women
City of Bloomington Community and Family Resources Department

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FOREWORD

In the fall of 2001, members of the City of Bloomington Commission on the Status of Women (BCSW) pored over findings in *The Status of Women in Indiana*, a report produced by the Institute for Women's Policy Research to establish baseline measures of the status of women. Of the fifty states, and the District of Columbia, Indiana ranks 43rd for reproductive rights and 44th in employment and earnings. Women have nowhere near adequate political representation in elected office, and Indiana falls far below the national average of women with four years or more of college education. These data make it plain that despite the fact that women have made significant economic, political and social strides since the passage of women's suffrage, we're still far from achieving gender equality.

Since one of the objectives of the BCSW is to monitor federal, state and local policies for their impact on Bloomington women and to make recommendations for appropriate actions to assure women's equity, commissioners felt strongly that we should produce a report specific to the status of women in our community. Indeed, the status of individual women is impacted by their geographical location, their education, their age, race and sexual orientation. We hope our report informs local citizens about the progress of women in Bloomington, provides information about women's progress in achieving rights and opportunities, identifies and measures remaining barriers to equality, and helps us examine the nature of women's progress in Bloomington. The data is intended to provide important baseline indicators and help improve the ability of members of our community to more effectively address women's issues.

We were fortunate to have a good model for our work in the *Status of Women in Indiana* report, and support from Charlotte Zietlow, who chaired the Indiana Advisory Committee, Pete Giordano, director of the City of Bloomington's Community and Family Resources Department,

and interested commission members and other talented volunteers. That said, the path to producing this report was fraught with challenges. Local data about women's employment and educational attainment, and personal well-being proved difficult to unearth. We immediately experienced set-backs simply because data were not disaggregated by gender, or because there was no central data source. In other cases, for example with the local school district and the judicial system, we could not secure permission to access information.

Given the local data collection challenges, we turned to other public data sources. Staff from the City of Bloomington Community and Family Resources Department, namely Lee Bowlen with the able assistance of Seth Brooke, pulled data from the U.S. Census Bureau (2000) and other public information systems, and organized it for our needs. The source of most of the data contained in the reports we are releasing is a combination of Census data, national comparison data from the Institute for Women's Policy Research (IWPR) report, and locally gathered data.

We continue to be reminded of the need to examine and monitor the status of women. For example, wage gaps persist even as states implement equal pay acts for public sector employees, enact bills requiring pay equity studies, and in 2005, promote the Equal Pay Remedies and Enforcement Act. These efforts require data to document disparities and measure progress. Yet, in February 2005, the U.S. Bureau of Labor Statistics (BLS) proposed to eliminate gender as a reporting category in a revision of the 'Report on Employment, Payroll, and Hours' (BLS-790). Clearly, the collection of gender specific data is one way to monitor wage disparities and to help ensure that employers are accountable for gender discrimination in the workplace.

Encouragement to produce this report came from many sources, but I want to acknowledge the inspiration provided by countless non-profit women's advocacy groups including the IWPR, a public policy research organization dedicated to informing and stimulating the debate on public policy issues of importance to women; Middle Way House, whose mission is to end violence in the lives of women and children by implementing or sponsoring activities and programs aimed at achieving individual and social change; governmental organizations including our own City of Bloomington Community and Family Resources Department, which serves to identify the community's social needs and to help develop solutions to address these needs; and the City of

Bloomington Commission on the Status of Women. These groups work tirelessly to improve the conditions and quality of life for women in our community.

Readers of the Commission on the Status of Women's *Report on the Status of Women in Bloomington and Monroe County* are encouraged to study, question and use the information provided here to advance the status of women and enrich our community by dedicating ourselves to establishing gender equity.

Jillian Kinzie
Chair, City of Bloomington Commission on the Status of Women

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INTRODUCTION

Beginning in 2005, the City of Bloomington Commission on the Status of Women will release five topical reports on the status of women – Economics, Employment and the Workplace; Political Participation and Leadership; Education; Victimization, Rights and Justice; and Health and Well-Being. These reports will be produced as a series to make them easier to print and update on an ongoing basis. We strongly recommend that readers of our report also review *The Status of Women in Indiana* report and other projects conducted by the Institute for Women's Policy Research (see www.iwpr.org) to get a fuller understanding of the status of women in Indiana and on a national level. We provide an overview of the state information here to offer readers some information about the broader context in which our work is situated.

Data about the status of women needs to be viewed in the context of data about the status of all citizens of Indiana, particularly when it comes to educational attainment, earnings, public assistance programs and other economic criteria. The economic status of Indiana women is relatively poor, the majority of policy makers are male, and Indiana is a fiscally conservative state, which leads to low taxes and low funding of public assistance programs. Indiana has one first-class city, Indianapolis (population over 350,000 but under 500,000), and 16 second-class cities. Indiana is a fiscally conservative state with a distinctly blue-collar economy. Indiana is one of the lowest states in terms of personal tax burden – ranked fourteenth on a scale where first is lowest. It is the lowest state in spending for both state and local governments. Nevertheless, it is noteworthy that in recent years, both the Voucher Program and the Children's Health Insurance Program (CHIP) have received strong support from the state. Participation in public office has been difficult for women in Indiana, but there are some bright spots.

Indiana women ranked below the median on most of the composite indices calculated by IWPR. The overview of *The Status of Women in Indiana* yields the following information on key

indicators: of the fifty states and the District of Columbia, Indiana ranks 24th, just above the middle for health and well-being and for political participation, but falls to 36th in economic autonomy and 44th in employment and earnings. Indiana does not ensure equal rights for women. An evaluation of Indiana's women's status compared with goals set for women's ideal status earns Indiana the grades of C+ in health and well-being, C in political participation, C- in economic autonomy, D- in employment and earnings, and an F in reproductive rights.

Indiana is the 14th largest state in the country with about 5.9 million people living within its borders; about 3 million of them are women. At the time of this survey, Indiana's women were less diverse than women nationally with proportionally fewer immigrants.

Women in Indiana register and vote at rates that are near average for the country as a whole, but are disproportionately under-represented in elected office. Women in Indiana participate in the workforce slightly more but earn lower wages and work less. They earn lower wages and work as managers or professionals much less often than women in the nation as a whole. At 48th, women's earnings in relation to men's are also consistently lower than in most of the country.

Indiana illustrates many of the difficult obstacles still facing women in the U.S. Although women as a whole are seeing important changes in their lives that by now lead to equality with men, they still lack many of the legal guarantees that would allow them to achieve the same equality.

HEALTH AND WELL-BEING

Health is a vital aspect of women's overall well-being and central to their ability to participate in all areas of public and private life. Health is a state of complete physical, mental and social well-being and not merely the absence of disease. Women's health comprises emotional, social and physical well-being and is influenced by the social, political and economic context of their lives, as well as by biology. Women have the right to the enjoyment of the highest attainable standard of physical and mental health. However, health and well-being elude the majority of women. The major barrier to the achievement of a high standard of women's health is inequality, both between men and women and among women in different geographical regions, social classes, sexual orientation and racial-ethnic groups. Women have emphasized that to attain optimal health throughout the life cycle, equality, including the sharing of family responsibilities, are necessary conditions.

National and international initiatives, such as the establishment of the President's Interagency Council on Women (PICW) in 1995, to ensure quality health care, full political and economic participation of women, equality, and the promotion of human rights for women, and the creation of National Centers of Excellence in Women's Health sponsored by the federal Office on Women's Health, coupled with state initiatives including the Indiana Office of Women's Health, have brought increased attention to women's health needs. These initiatives demonstrate the crucial need to help advance women's health research, services, and public and health professional education and to develop programs and activities to enhance services available to women and reduce fragmentation in women's health services.

An important aspect of efforts to improve women's health and well-being is to scrutinize the status of women's health. The goal of this report is to provide information about the status of women's health and well-being in Bloomington and Monroe County across several major

indicators: state health policies and insurance; incidence of disease and mortality; mental health; fertility, natality and infant care; preventive care and health behaviors; reproductive health and rights; access to abortion; and other family planning policies.

STATE HEALTH POLICIES AND INSURANCE

Women have different and unequal opportunities for the protection, promotion and maintenance of their health. At a national level, women are more likely to be uninsured than men. However, the 2003 Indiana Behavioral Risk Factor Surveillance System (BRFSS) survey found that nearly the same number of women and men in Indiana report not having any kind of health coverage -- 14.4% of men and 13.0% women. An estimated 15% of Monroe County respondents reported not having any health coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare. Another question on the BRFSS survey asked if there was a time in the past 12 months when the respondent needed to see a doctor but couldn't because of cost. An estimated 14% of Monroe County respondents answered "yes" to this question. For the state as a whole, 10.2% of males and 15.7% of females reported not being able to see a doctor when they needed to in the last twelve months because of cost. The BRFSS survey was conducted with a random sample of non-institutionalized adults over age 18 via telephone; the survey was done in cooperation with the Centers for Disease Control and Prevention. Data are reported at the state level; the sample size of respondents in Monroe County was insufficient for breaking data down by gender or ethnicity at the county level, although overall county estimates can be reported (Indiana State Department of Health, Epidemiology Resource Center, 2006).

Although health insurance coverage makes health care affordable and accessible for millions of women in the United States, about 14% of American women 18 years and older are uninsured, and one in five women of reproductive age is uninsured. Poor women are four times more likely than non-poor women to lack health insurance (National Women's Law Center, 2005). According to the report, *Women and Health Coverage: The Affordability Gap* (2007), women have more difficulty affording health care services even if they have insurance. Because women tend to have lower incomes than men and have greater difficulty paying premiums, they are less likely than men to have coverage through their own employer and are more likely to obtain coverage through their spouses. In addition, women are more likely than men to have higher out-

of-pocket health care expenses; and use more healthcare services than men and consequently are in greater need of comprehensive coverage. Latino and African-American women are two to three times more likely to be uninsured than are white women -- 37% of Latino women and 23% of African-American women are uninsured, compared to 13% of white women. Across all racial-ethnic groups, the lack of health insurance contributes to poorer health outcomes. When they are uninsured, women are considerably more likely to postpone care than their insured counterparts and often forego important preventive services such as mammograms and Pap tests.

Indiana does not require private insurers to cover cervical cancer screening or osteoporosis screening; it *does* however require them to cover breast cancer screening. Indiana also requires private insurers to cover colorectal cancer screening, which the majority of states do not. (Making the Grade on Women's Health, 2004)

Indiana Health Insurance Mandates, 2004

Does the state require private insurers to…	Yes	No
Cover cervical cancer screening?		X
Cover breast cancer screening?	X	
Cover osteoporosis screening?		X
Cover depression on the same basis as other medical conditions?	X	

The U.S Department of Health and Human Services reports that girls and women are simply not getting enough regular physical activity. Only 4 in 10 women are engaging in recommended levels of physical activity. Activity decreases with age and is less common among women than men and among those with lower income and less education. Indiana requires less than four years of physical education in high school, which "Making the Grade" describes as a limited policy. The Indiana CORE 40 diploma requires only one credit, or two semesters of physical education. Beginning in the 2006-2007 school year, the CORE 40 diploma will require two credits of physical education. However, this is misleading, because it will not require any additional semesters.

About 14% of young people report no recent physical activity. Inactivity is more common among females than males (14% versus 7%), and more common among black females than white females (21% versus 12%) (Making the Grade on Women's Health, 2004). Bloomington High Schools North and South only require one credit of physical education.

INCIDENCE OF DISEASE AND MORTALITY

Heart disease is the number one cause of death for both women and men of all ages. It kills more than any individual type of cancer, and almost as much as all cancers combined. Of the total 313 female deaths in Bloomington in 2002, 74 (23.6%) were due to heart disease. Nearly 25% (75) of female deaths were due to cancer; 13 of these were from breast cancer (Indiana State Department of Health). The leading cause of death in 2002 for both women and men (with more female mortalities) in Indiana was heart disease. The next highest mortality rate was from cancer (Indiana Mortality Report, 2004). Of the 389 female deaths in Monroe County for 2002, 92 were from heart disease and 87 were from cancer, 13 of which were breast cancer. From 1995 to 1999, the rate of death from cardiovascular disease in Monroe County was significantly lower than the rate for the state of Indiana. In 1999, there were 14 deaths from diabetes among women in Monroe County, and 754 in Indiana. The overall death rate in Monroe County was also significantly lower than the state's (Indiana State Department of Health Office of Women's Health, 2001). Concern about women and heart disease prompted the Indiana Office of Women's Health to launch an educational campaign to create awareness of the facts of heart disease in women and provide information on risk factors, symptoms, and to seek aggressive diagnosis and treatment. In 2007, The Indiana State Department of Health convened a forum on women's health regarding the issue of tobacco use among Indiana women and specifically the marketing of tobacco products to young women (see: http://www.in.gov/isdh/programs/owh/INFluence.htm).

Female Deaths from Selected Causes Bloomington 2002 *(Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, April 2004.)*			
	All Races	**White**	**Black**
All Cancers	**78**	**73**	**5**
Cancer of the Lungs, Trachea, Bronchus	21	20	1
Breast Cancer	13	13	0
Cancer of the Cervix, Uterus, and Ovaries	5	4	1
Leukemia	1	1	0
Heart Disease	**74**	**71**	**2**
Influenza and Pneumonia	**15**	**15**	**0**
Motor Vehicle Accidents	**3**	**3**	**0**
Homicide	**2**	**2**	**0**
Suicide	**1**	**1**	**0**

Within Indiana, there were 104 homicide deaths for women in 2002. In Monroe County, there were two female homicide deaths, both in Bloomington. About four times as many men commit suicide as women, although women report attempting suicide three times as often as men (Suicide in the U.S.: Statistics and Prevention, 2006). Of the ten suicides in Bloomington, only one was a woman. Racial differences exist in the death by homicide in Indiana. Homicide is the leading cause of death for African American women between the ages of 15 and 34, while motor vehicle accidents are the leading cause of death for this age group among white women (Indiana State Department of Health, 2004).

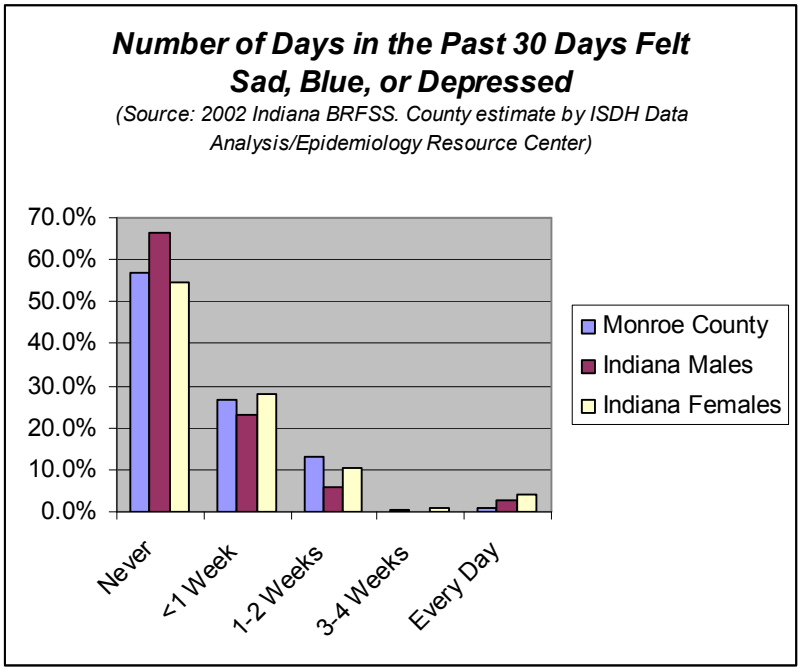
Statewide, there are more cases of Sexually Transmitted Diseases (STDs) among black women than white women. There were 5,588 incidences of Chlamydia among black women and 5,051 among white women; there were 4,072 cases of gonorrhea among black women, and 1,275 among white women. In Monroe County, although the incidence of STDs is higher for white women than for black women, a higher *percentage* of black women report STDs than white women. Through December 2000, there were five cases of HIV reported in Monroe County (among women), and 13 cases of AIDS reported---eight to white women. At the state level,

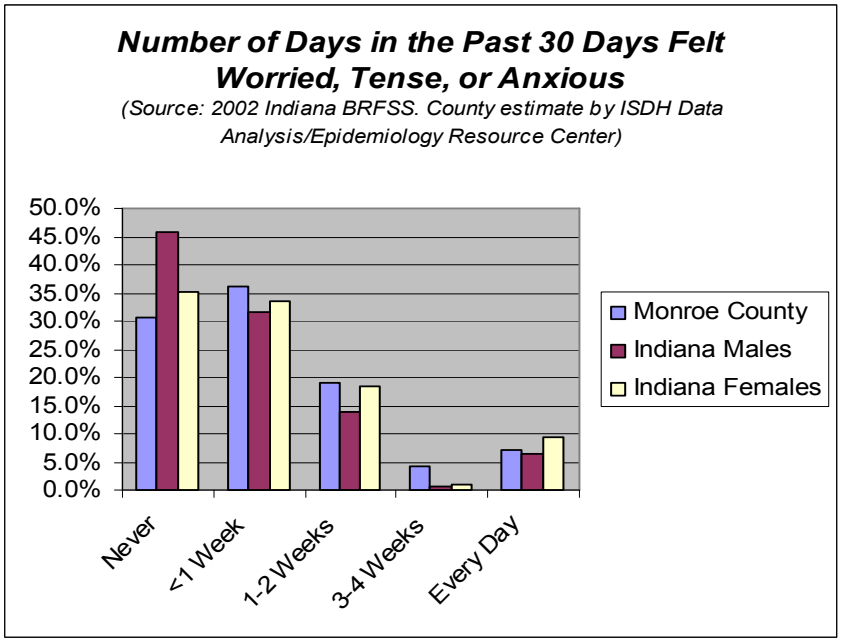
there were fewer cases of HIV reported for black women than white women, but more cases of AIDS reported among black women than white women.

Although the statistics concerning STDs are an important indicator of sexual health, a more complete picture of sexual health would also consider the extent to which women report healthy sexual relations and the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

MENTAL HEALTH

The 2002 BRFSS survey asked the number of days in the past month the respondent had felt sad, blue, or depressed. Women were less likely than men to say 'never,' and more likely to answer 'less than one a week,' '1-2 weeks,' '3-4 weeks,' and 'every day.' Monroe County respondents were less likely to answer 'never' than the state as a whole, and more likely to answer 'less than one week' and '1-2 weeks,' but they were less likely to answer '2-4 weeks' or 'everyday.' The survey also asked the number of days the respondent felt worried, tense, or anxious. The results were similar to the first question at the state level, but Monroe County respondents were much more likely to answer 'less than one week,' '1-2 weeks,' '3-4 weeks,' and 'everyday" (Indiana State Department of Health, Epidemiology Resource Center). Indiana requires parity - with some exceptions - for mental health problems and substance abuse. The state also requires insurers to cover depression on the same basis as other medical conditions (Making the Grade on Women's Health, 2004).





FERTILITY, NATALITY AND INFANT HEALTH

The right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant is a central health concern for women. The 2002 crude birthrate (the crude birth rate, an

indicator of population growth, is the number of childbirths per 1000 persons per year) for Bloomington was 11.1 (for comparison purposes, the crude birthrate for the United States has been about 14 for several years). In 2002 there were 774 total births, with 6.3% of babies having low birth weight, and 1.0% having very low birth weight. 8.4% were delivered pre-term. 81.0% of mothers received prenatal care in the first trimester, compared with 80.5% for the state as a whole. 1.2% of Bloomington mothers consumed alcohol during their pregnancy, and 16.3% smoked. For Indiana, these figures were 0.7% and 19.1%. 31.3% of births were to unmarried parents, compared to the state average of 36.5% (Indiana Department of Health, Epidemiology Resource Center, Data Analysis Team).

Bloomington Natality Report 2002 *(SOURCE: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team, March 2004)*	
Birth Weight	
% Low	6.3
% Very Low	1
% Pre-term	8.4
Prenatal Care During First Trimester	82.5
During Pregnancy	
% Used Alcohol	1.2
% Smoked	16.3
Percent born to unmarried parents	7.1

PREVENTIVE CARE AND HEALTH BEHAVIORS

According to the U.S. Office for Women's Health, behavioral and lifestyle factors constitute over 50% of the causation of all 10 of the leading causes of death in American women. As many as one million premature deaths in the U.S. could be prevented through changes in behavior. Preventative screening is central to increasing healthy behaviors. The estimate from the 2002 Indiana BRFSS survey for Monroe County was that 8.0% of women 18 years and older had not had a pap smear in three years; for the state, the figure was 14.3%. The survey also determined that at the state level, 15.6% of women age 40 and above had not had a mammogram in 2 years; there were no estimates available for Monroe County for mammograms (Indiana State

Department of Health, Epidemiology Resource Center). Breast cancer screenings are crucial not just for detecting breast cancer but also for reducing breast cancer mortality. Public awareness and insurance coverage campaigns are central to reducing death rates from the disease.

Females in Monroe County were at slightly higher risk for heavy alcohol consumption than women in Indiana as a whole. From the 2003 BRFSS survey, it was estimated that 6.2% of females in Monroe County were at risk for heavy alcohol consumption, compared to 4.2% of females in Indiana. An estimated 23.4% of Monroe County residents smoke every day or some days. At the state level, 28.5% of men and 23.7% of women smoke. The percentage of men and women in Monroe County who had no physical activity in the past month was lower than the percentage at the state level---22.8% of men and 29.3% of women (Indiana State Department of Health, Epidemiology Resource Center, County Estimates).

REPRODUCTIVE HEALTH AND RIGHTS

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease, in all matters relating to the reproductive system and to its functions and processes. Complete reproductive health implies that people are able to have a safe and satisfying sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning and the right of access to reproductive health-care services.

Family planning enables women to decide freely and responsibly the number and spacing of their children, and to have the information and means to do so. It also means that women have ongoing availability of a full range of safe and effective contraceptive methods that enable them to take action according to these decisions. This ability to take action is also based upon access to family planning services, the cost and availability of various contraceptives, insurance coverage, and the support or lack thereof from partners, extended family members, and the wider community. Family planning services are available to women through private care physicians, hospitals and clinics. In Monroe County, access to affordable services is an ongoing concern. Moreover, in 2006, Indiana still does not require health insurance companies to cover any form

of contraception, yet 360,680 women in Indiana are in need of publicly funded contraceptive services (Alan Guttmacher Institute).

There are about 101 publicly funded family planning clinics in Indiana serving a total of 147,260 female contraceptive clients of all ages and serving a total of 43,670 female contraceptive clients under the age 20 years (Contraceptive Needs and Services, 2001 and 2002, The Alan Guttmacher Institute). The table below compares family planning service delivery between Indiana and the U.S. (Access to Family Planning Fact Sheet, Indiana State Department of Health). Note the significant proportion of family planning services provided by Planned Parenthood in Indiana in comparison to the rest of the U.S.

Publicly funded family planning clinics by type of provider, 2001- Indiana and U.S.

	Indiana		U.S.	
	Number	%	Number	%
Hospitals	19	18.8	813	10.6
Health department	7	6.9	2,874	36.2
Planned Parenthood	**44**	**43.6**	**889**	**11.6**
Community Health Center	16	15.8	1,730	22.5
Other	15	14.8	1,377	17.9
Total	101	100	7,683	100

Source: Contraceptive Needs and Services, 2001-2002. Retrieved from www.guttmacher.org/pubs/win/index.html.

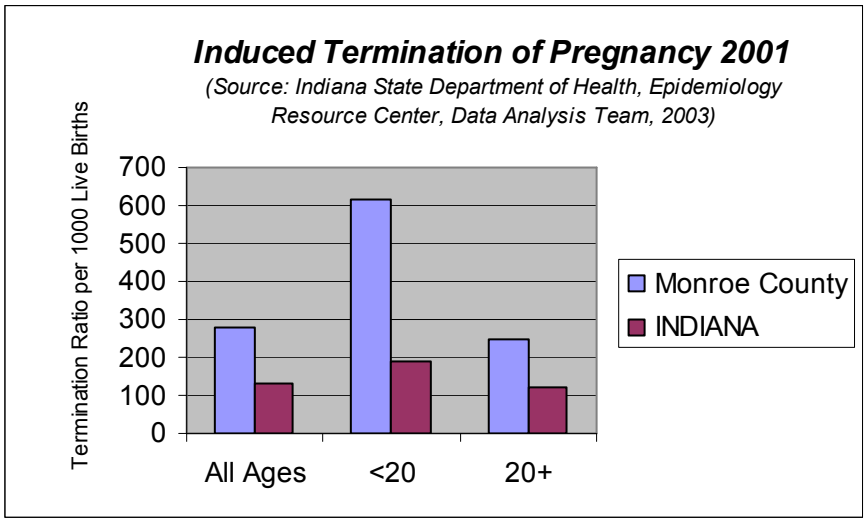
During 2001, family planning clinics in Congressional District 9 (including Monroe County) served 6,640 teenagers (Alan Guttmacher Institute). The Planned Parenthood in Bloomington specifically is the largest Planned Parenthood in the state, and served 7,106 patients in 2005, 22% of which were under the age of 19. Despite efforts from family planning clinics, Indiana ranks 49th in the nation in preventing unintended pregnancy and clinics reach only 41% of teenagers in need (Planned Parenthood of Indiana). Access to high quality family planning and contraceptive services will continue to be an important factor in promoting healthy pregnancies and preventing unintended pregnancy in Monroe County.

REPRODUCTIVE RIGHTS

Indiana received a grade of "F" from NARAL Pro-Choice America (formerly National Abortion and Reproductive Rights Action League) for reproductive rights. The state has several laws in place restricting women's access to abortion. Indiana law requires that the parent of a minor must give consent before she can have an abortion. Currently, the state of Indiana also requires that women of all ages must receive mandatory state-directed counseling and wait 18 hours before an abortion can be provided. Public funding is only available for abortion in the case of incest, rape, or life endangerment. According to NARAL (2005), Indiana's governor, lieutenant governor, and attorney general are all opposed to a woman's right to choose, as are the Indiana House and Senate. According to one study, 93% of Indiana counties have no abortion provider, and 62% of Indiana women live in these counties. Due to this lack of access, many Indiana women were forced to travel considerable distances to obtain abortions -- in the Midwest census region, 28% of women having abortions traveled at least 50 miles, and 10% traveled more than 100 miles (Alan Guttmacher Institute, 2000).

Currently Indiana does not require health insurance companies to cover any form of contraception, yet 360,680 women in Indiana are in need of publicly funded contraceptive services (Alan Guttmacher Institute 2000).

In 2001, Monroe County had 1,280 births---117 to mothers under the age of 20, 1,163 to mothers 20 years of age and older. The termination ratio, per 1000 births, is 281.3 for Monroe County (there is no way to know that these are Monroe County residents). The ratio is significantly higher for women under 20 than for women 20 and over -- 615.4 terminations per 1,000 live births versus 245.1 per 1,000 live births (all other counties reported far lower termination rates for mothers under 20 than Monroe County). At the state level, there was a 132.0 termination ratio -- 190.4 for mothers under 20, 121.4 for mothers 20 and older (Indiana Department of Health, Epidemiology Resource Center, Data Analysis Team).



Access to Emergency Contraception (Plan B)

In August 2006, the Food and Drug Administration granted emergency contraception (also referred to as Plan B® or the "morning after pill") over-the-counter status, a decision that will increase women's reproductive health choices. Although emergency contraception is often mistakenly described as a type of abortion, it is actually a high dosage of birth control that prevents ovulation, fertilization, or implantation of an egg. Since the effectiveness of emergency contraception depends on how quickly Plan B® is taken after unprotected intercourse, eliminating the necessity of acquiring a prescription eases the burden on women and increases the chances of Plan B® working successfully. Easy, universal access to emergency contraception is an important reproductive right for women and an essential tool to fight unwanted pregnancies; it is estimated that if Plan B® is widely available, up to 1.5 million unintended pregnancies (and 800,000 abortions) would be prevented (Planned Parenthood of Indiana). Many Indiana residents desire emergency contraception; in 2005, Planned Parenthood supplied more than 23,000 prescriptions for this method of birth control. The Planned Parenthood in Bloomington provided 1,987 packets of emergency contraception in the same year.

However, the recent FDA ruling is only a partial victory for women's reproductive freedom, as it stipulates that only women over the age of 18 will be able to purchase emergency contraception over the counter at pharmacies. Women under this age will only be able to obtain emergency contraception through prescription, complicating the process for younger women and increasing

the likelihood that women will not be able to take it in time. Pharmacists in Indiana are also allowed to refuse to fill prescriptions for emergency contraception based on personal moral objections to this method of birth control; women under the age of 18 will continue to confront this barrier to accessing Plan B®.

Restricting women under the age of 18 from purchasing emergency contraception is significant for the women of Indiana: Indiana has the 31st highest teenage pregnancy rate in the nation and ten teenagers under the age of sixteen become pregnant each day (Alan Guttmacher Institute, Planned Parenthood of Indiana). In 2000, 16,020 women in Indiana between the ages of 15-19 were pregnant (Alan Guttmacher Institute). Despite the efforts of family planning clinics in congressional district 9 (including Monroe County), which served 6,640 teenagers (Alan Guttmacher Institute), Indiana ranks 49th in the nation in preventing unintended pregnancy and clinics reach only 41% of teenagers in need (Planned Parenthood of Indiana).

Not only do minors continue to face difficulties obtaining emergency contraception, Plan B® is also not easily available to low-income women. As indicated earlier, currently Indiana does not require health insurance companies to cover any form of contraception, yet 360,680 women in Indiana are in need of publicly funded contraceptive services (Alan Guttmacher Institute). Of these women, 105,490 of these women are under the age of 20, while 48,000 are African-American, and 20,060 are Hispanic (Alan Guttmacher Institute, data for 2001-2002). 68% of Planned Parenthood's patients in Bloomington have incomes below the federal poverty line. Nationally, 17.4 million women were in need of publicly funded contraceptive services and supplies in 2004 (Alan Guttmacher Institute). According to Barb Sturbaum of Planned Parenthood of Indiana, when Plan B® becomes available over the counter, the cost will rise (it currently costs $20-25). Federal Title XX funds allows Planned Parenthood to provide Plan B® free to low-income women, yet as available funding diminishes and costs of supplies rise, clinics like Planned Parenthood are not recovering the costs for providing free emergency contraception. Minority women are disproportionately affected by rising costs and lack of public funding for reproductive health. Moreover, one must be an Indiana resident and have a Social Security number to be eligible for free emergency contraception, requirements that prevent low-income undocumented women from accessing Plan B®.

Emergency contraception is available for free to sexual assault victims at Planned Parenthood and at Bloomington Hospital. If a doctor at Bloomington Hospital opposes prescribing or recommending emergency contraception, the hospital has a policy to ensure that victims will receive Plan B®. The statewide sex crimes victim services fund initially reimbursed Bloomington Hospital for the prescription, but in 2006, state policy changed. Government is no longer willing to cover emergency contraception – even for rape victims. Although Bloomington Hospital has agreed to cover the cost for victims who have financial need and no other form of coverage, the policy change represents a step backwards for providing necessary health care to women who are crime victims.

Crisis Pregnancy Centers

Crisis pregnancy centers (also known as pregnancy resource centers) are usually not medical facilities, but anti-choice organizations that attempt to dissuade women from having abortions and to support them through their pregnancy. The mission of the Central Indiana Crisis Pregnancy Center is: "to affirm the value of life by providing a network of care to those experiencing pregnancy-related crisis and by compassionately presenting Biblical truth resulting in changed lives to the glory of God" (http://www.cicpc.org/index.php). These centers are often listed under terms such as "pregnancy," "medical," "women's centers," "clinics," or "abortion services" in the phone book and are sometimes located near legitimate abortion providers to attract women considering abortion. According to a report prepared for Representative Henry Waxman, these centers often tell potential clients that abortion increases the risk of breast cancer and leads to future infertility and mental illness, although the National Cancer Institute, the American Psychological Association, and recent obstetrics research have denied the validity of such claims. These centers also do not usually inform potential patients that they are anti-choice and/or religious organizations (National Abortion Federation 2003 report).

For example, a Planned Parenthood of Indiana patient reported that she mistakenly entered a crisis pregnancy center that was located next door to Planned Parenthood. After obtaining her personal contact information, staff repeatedly called her cell phone and her home, and visited her home and work attempting to convince her not to have an abortion. The woman reported that

staff told her that she would die or ruin her life if she chose to have an abortion, and they also shared information with her school (Planned Parenthood of Indiana).

According to the National Abortion Federation, 4,000 crisis pregnancy centers exist in the United States today, compared with the 2,000 clinics that provide actual abortion services. There are more than 100 crisis pregnancy centers in Indiana. These centers are acquiring increasing federal funding while clinics like Planned Parenthood are losing funding. Between 2001 and 2005, crisis pregnancy centers received over $30 million in federal funding largely though funds marked for abstinence-only education programs and President Bush's Compassion Capital Fund initiative.

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Another source of funding for crisis pregnancy centers is "choose life" license plates, the proceeds of which benefit crisis pregnancy centers. The Indiana Bureau of Motor Vehicles recently approved these plates for sale in 2007, a measure Governor Mitch Daniels also supports. The Indiana Association of Pregnancy Centers (a coalition of crisis pregnancy centers) will receive an estimated $3 million from the sale of "choose life" license plates. "Choose life" license plates have been legally challenged in Tennessee, and the use of deceptive tactics and public funds by crisis pregnancy centers has been successfully challenged in courts in several states, not including Indiana. Nationally, Representative Carolyn Maloney has introduced a bill called "Stop Deceptive Advertising in Women's Services Act" which would authorize the Federal Trade Commission to regulate the advertising practices of crisis pregnancy centers.

OTHER FAMILY PLANNING POLICIES

The Indiana Department of Education recommends that schools include sex education as part of their health curriculum, but it does not require schools to teach it. According to state law, abstinence outside of marriage is to be stressed if sex education is taught. There is no federal law requiring schools to teach sex education. Indiana does require that high schools include

instruction on breast cancer and testicular cancer, including the importance of early detection (Planned Parenthood of Indiana 2005)

CONCLUSIONS AND RECOMMENDATIONS FOR WOMEN'S HEALTH

Health is a crucial factor in women's overall well-being. This report indicates that the quality of women's health in our community warrants some concern. The need for strong prevention programs and information campaigns targeting all groups of women, and adequate and affordable quality health care persists. Racial disparities in women's health status in Indiana are evident in many indicators of women's health and well-being. For example, among all cancers, death rates for African American women are higher than those of white women in Indiana.

To better address the health needs of women, we need improved data collection including more health and well-being data separated by race and gender and available at city and county level. Given that women experience certain psychological disorders, such as depression, anxiety, panic disorders and eating disorders at higher rates than men, additional data is needed around issues of mental health. Most importantly, more data is needed on health care and insurance coverage. Finally, the Office of Women's Health could do more to collect these data, and then release the County Data Book more frequently.

Given that sexually transmitted diseases are a common threat to younger women's health, and that the incidence of HIV and AIDS in women is one of the fastest growing risks to young women's health, the need for greater education, awareness and proper screening is critical. Greater access to comprehensive sex education, instead of abstinence only, is one effective approach to curbing these threats.

Although issues pertaining to reproductive rights and sexual health can be controversial, the reality is that women, and particularly adolescent girls and young women, need information and access to relevant information and services. Comprehensive sex education is again key to providing young women the information they need to make educated and more informed choices about sexual activity and reproductive health. Access to planning and education is important.

Bloomington Hospital should reapply for a grant from Indiana Family Health Council or another local agency should apply to manage a family planning clinic.

The Indiana state legislature continues to diminish and threaten women's access to reproductive health care. The battle over access to birth control and abortion, including parental consent and notification, and mandatory waiting periods, and public funding for abortion show no signs of abating. Ongoing efforts to outlaw and severely restrict access to abortion are probably the most serious threats to women's health in Indiana. Legislative action to restrict women's access to reproductive health care is in all respects a complete assault on women's rights. Women in Indiana need increased access to accurate family planning information, emergency contraception, abortion, and parental consent and notification and mandatory waiting periods should be eliminated. Women need to have complete and unrestricted access to make informed decisions about their reproductive health care needs. Furthermore, the policy change in the sex crime victims fund that eliminated emergency contraception care for rape victims in Indiana represents a step backward for assuring women necessary health care. The policy should be amended so that regardless of ability to pay or insurance coverage, all rape crime victims are assured of getting the care they need.

Regular physical activity throughout a woman's life is important for maintaining a healthy body, enhancing psychological well-being, and preventing premature death. Yet, girls and young women are not developing healthy levels of physical activity and habits that will serve them well as adults. To increase physical activity, K-12 education should require more than two semesters of physical education, and opportunities for after school activities should be expanded to include more physical education.

Many women's health issues are preventable. Therefore, it is important to create and implement a health care system that increases access and responsiveness to women, both in the preventative and treatment stages. An important aspect of prevention is insurance. Insurance coverage should be mandated for: cervical cancer screening, osteoporosis screening, contraceptives, and mastectomy hospital stays. Furthermore, in addition to making Medicaid more effective for low

income women, the number of women on Medicaid should be reduced and the number of employers offering women insurance coverage should be increased.

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